

269153

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>9/14/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>REST LAWN MEMORIAL GDN LA VALE</b>	23d. LOCATION CITY OR TOWN <b>ALLEGANY</b> COUNTY <b>ALLEGANY</b> STATE <b>MD</b>
24. FUNERAL DIRECTOR <b>SOWERS FUNERAL HOME</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1985</b> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

27b. SIGNATURE <i>[Signature]</i>		27c. DATE SIGNED <b>9-11-85</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Mehanna, M.D.</b>		27e. ADDRESS <b>909-B Seton Drive Cumberland, MD 21502</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-9</b> , 19 <b>85</b> , to <b>9-11</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>9-11</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>HOME</b>			
22c. LOCATION STREET CITY OR TOWN COUNTY STATE			
22d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
22e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			
22f. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
22g. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK			
22h. DATE OF OPERATION			
22i. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22j. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
22k. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Helicobacter Co of Coloca</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>to liver</b> DUE TO, OR AS A CONSEQUENCE OF (c)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> 16b. SOCIAL SECURITY NO. <b>1051-1953 216301748</b>			
17. INFORMANT <b>FROSTBURG, MD 21532</b> <b>MRS. JAMES ALDERTON, 60 MT. VERNON ST.</b>			
14. FATHER'S NAME FIRST <b>CLYDE</b> MIDDLE <b>ALDERTON</b> LAST <b>WILMA</b>		15. MOTHER'S MAIDEN NAME FIRST <b>WILMA</b> MIDDLE <b>WENTLING</b> LAST <b>WENTLING</b>	
13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>ALLEGANY</b> 13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OWNER-MGR.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OPTICIAN</b>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>		10. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, MD.</b>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS. MONTHS <b>21</b> DAYS <b>3</b> HOURS <b>25</b> MIN.	
7. DATE OF BIRTH <b>11/27/30</b> MONTH <b>11</b> DAY <b>27</b> YEAR <b>30</b>		6. DATE OF DEATH <b>September 11, 1985</b> MONTH <b>9</b> DAY <b>11</b> YEAR <b>1985</b>	
5. RACE <b>WHITE</b>		4. SEX <b>MALE</b>	
3. DECEASED NAME (TYPE OR PRINT) <b>James Wentling Alderton</b>		2. DATE OF DEATH <b>September 11, 1985</b>	
1. FOR STATE REGISTRAR <b>60 W. Main Street Frostburg, MD 21532</b>		1. DECEASED NAME (TYPE OR PRINT) <b>James Wentling Alderton</b>	

JOHN MEMORIAL, N.D. 509-5 Gordon Drive Cumberland, MD 21501

BURIAL 5/14/85 WEST LAWN MEMORIAL GDN LAVALLE ALLIANCE MD  
60 W. MAIN ST.  
FROSTBURG FROSTBURG

296137

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert		MIDDLE Lee		LAST Allen Jr.		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10 15 1985		2b. HOUR 7:05 P.M.	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 / 22 / 27		6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 15 1985		2d. HOUR 7:05 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Treat. Engineer		12b. KIND OF BUSINESS OR INDUSTRY Chemical			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 267 / 21555			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Allen, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Odessa Allen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Doris T. Allen - same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intra cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) due to Hypertension. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francisco Reyes				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 10-15-85			
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes				ADDRESS 900 seton Dr. Cumberland, Md. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/19/85		23c. NAME OF CEMETERY OR CREMATORY Olivers Grove Ceme.				23d. LOCATION CITY OR TOWN COUNTY STATE Oldtown, Alleg., MD			
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.						ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR OCT 21 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

SECRET

NO. 1  
12/22/51

USA

Robert J. Lee  
12/22/51

Robert J. Lee  
12/22/51

Robert J. Lee  
12/22/51

Robert J. Lee  
12/22/51

Robert J. Lee  
12/22/51

Robert J. Lee  
12/22/51

Robert J. Lee  
12/22/51

Robert J. Lee  
12/22/51



309021

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDITH B. ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR October 21, 1985			2b. HOUR 8:15 P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 5 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 215 Cumberland St. 21502		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Yeager			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 235-34-1451	
17. INFORMANT ADDRESS Betty Jo Murphy Same as # 13 above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopalmory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Vascular Collopy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH <u>4 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (a) (this hospital) attended the deceased from <u>10-11</u> , 19 <u>85</u> , to <u>10-21</u> , 19 <u>85</u> , that (b) (we) last saw the deceased alive on <u>10-21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (c) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Bollino</u>			DEGREE <u>2nd</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>22 Oct 85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Anthony Bollino			22e. ADDRESS 955 Frederick St. Cumberland, MD 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-24-85		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME Wendy N. Upchurch George-Upchurch Fun'l. Home			ADDRESS 202 Greene St. Cumb., MD			25a. DATE REC'D. BY REGISTRAR NOV 01 1985			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers, Pages 1 and 2, and 2 should be kept until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

309031

RECEIVED

CHIEF WAVE

305124

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 2 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>LILLIAN HILDA ASH</b>			2a DATE OF DEATH MONTH DAY YEAR <b>October 26, 1985</b>		2b HOUR <b>6:20 A.M.</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JULY 4 1903</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10 CITY OR TOWN OF DEATH <b>Cumberland</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED GROCERY STORE OWNER</b>		
12b KIND OF BUSINESS OR INDUSTRY						
13a STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>CUMBERLAND</b>		
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>324 COLUMBIA STREET 21502</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>HENRY THOMAS WILLIAMS</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JANE PHILLIPS</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>218-30-0245</b>		17 INFORMANT ADDRESS <b>GAIL ASH 324 COLUMBIA ST. CUMBERLAND MD.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Streptococcal</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Malnutrition, Severe; Multiple decubiti</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.						
22b SIGNATURE <b>Dr. Guy Fiscus</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>OCT 27, 1985</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Guy Fiscus</b>		22e ADDRESS <b>Memorial Hospital Medical Building Cumberland, MD 21502</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>OCT 28 1985</b>		23c NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MD.</b>						
24 FUNERAL DIRECTOR NAME ADDRESS <b>SILCOX-MERRITT FUNERAL HOME CUMBERLAND MD.</b>		25a DATE REC'D. BY REGISTRAR <b>OCT 30 1985</b>		25b REGISTRAR'S SIGNATURE <b>Julia Davidson</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copiers pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

NEWMAN FUNERAL HOME P.O. BOX 267 GRANTSVILLE, MD 21536				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 2 6 9 3 0			
1. FOR STATE REGISTRATION				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSELLA ASH BAKER				2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 9, 1985				2b. HOUR 8:50 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 80		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA 13b. COUNTY Somerset 13c. CITY OR TOWN Springs				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE (P.O. Box 73) 15562					
14. FATHER'S NAME FIRST MIDDLE LAST Jonas Ash				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Yoder							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Kay L. Marshall, Carlisle, PA		116 ADDRESS 116 Wagner St.		17013			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Spont. cell tumor of stomach</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 3 MONTHS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>8-4</i> 19 <i>85</i> , to <i>10/9</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>10/8</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Phillip J. Schroeder</i>				DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PHILLIP J. SCHROEDER, MD				22e. ADDRESS P.O. BOX 2455 CUMBERLAND, MD 21512							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-11-85		23c. NAME OF CEMETERY OR CREMATORY Springs Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Springs, Somerset, PA					
24. FUNERAL DIRECTOR NAME ADDRESS <i>D. Newman</i> Grantsville, MD				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

editions

ALLBANY COUNTY



305125

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 3 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Merrill Melvin Bittinger			2a. DATE OF DEATH MONTH DAY YEAR 10/20/85		2b. HOUR 10:07 PM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 2/ 8/ 36		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co. MD.	
10. CITY OR TOWN OF DEATH Frostburg, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY Woolen Mill	
13a. STATE Md		13b. COUNTY Garrett	13c. CITY OR TOWN Grantsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt 1 Box 133 21536
FATHER'S NAME FIRST MIDDLE LAST John --- Bittinger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie --- Bittinger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 32 3798		17. INFORMANT ADDRESS Viola Bittinger Route 1, Box 133 Grantsville, MD 21536	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease &amp; plaque</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (id) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. S. Kim</u>		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Kim		22e. ADDRESS Main St., Westernport, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-23-85	23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bittinger, Garrett, MD
24. FUNERAL DIRECTOR NAME Newman Funeral Homes, P.A.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 31 1985			

MEDICAL CERTIFICATION

302152



297027

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 3 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN LAWRENCE BLAND			2a. DATE OF DEATH MONTH DAY YEAR October 12, 1985		2b. HOUR 7:46 P.M.						
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 04-15-1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY textile			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 496 Williams Street/21502			
14. FATHER'S NAME FIRST MIDDLE LAST John F. Bland						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Howe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-8693		17. INFORMANT ADDRESS Mrs. Juanita G. Bland, Cumberland, MD-wife							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

*Diabetes mellitus, Gangrene @ foot, Hysteria 6D bleeding*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9-22</u> , 19 <u>85</u> , to <u>10-12</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10-12</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Ramirez</i>				DEGREE		22c. DATE SIGNED 10-14-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Barrera, MD				22e. ADDRESS Medical Building, Memorial Hospital & Med. Center, Memorial Ave., Cumberland MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-15-1985		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 10-18-85			

100-100

100% COTTON FIBER

CHIEF IN M BOND



296155

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 3 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRY IRVIN BOHN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 12, 1985</b>		2b. HOUR <b>8:45</b> P M		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07/22/1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>73</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Trackman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>PA Bedford Buffalo Mills</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>R D 1/15534</b>		<b>99999</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Bohn</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tillie Shroyer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>159-12-5787</b>		17. INFORMANT ADDRESS <b>Mary Crislip, Hyndman, PA 15545</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

**Pulmonary embolism**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Arteriosclerotic Heart Disease. Bullous Emphysema**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **10-6**, 19 **85**, to **10-12**, 19 **85**, that (I) (we) last  
saw the deceased alive on **10-12**, 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING ☒ MEDICAL ☐ STAFF  
PHYSICIAN DIRECTOR PHYSICIAN

**R. Barrera MD****Medical Bldg., Memorial Hospital & Medical  
Center, Memorial Ave., Cumberland MD 21502**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)  
**Burial**

23b. DATE

**10/15/85**

23c. NAME OF CEMETERY OR CREMATORY

**Lybarger Cemetery**23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

**RD, Buffalo Mills, Bedford, PA**

24. FUNERAL HOME

**Harvey H. Zeigler, Hyndman, PA**

ADDRESS

**15545**

25. DATE REC'D. BY REGISTRAR 25a. REGISTRAR'S SIGNATURE





SILCOX-MERRITT FUNERAL HOME STATE OF MARYLAND  
 1. STATE 404 DECATUR STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HAROLD AUSTIN BOSLEY			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 8, 1985			2b. HOUR 4:00P M			
3. SEX Male		4. RACE White-Cau.		5. DATE OF BIRTH MONTH DAY YEAR 3 21 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Celanese		12b. KIND OF BUSINESS OR INDUSTRY Textile	
13a. STATE W.VA.		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RFD# 3 26726 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Bosley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Lynch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-10-4458			17. INFORMANT ADDRESS RFD# 3 Mrs. Dorothy Bosley Keyser, W.Va 26726			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 yrs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>78</u> to <u>Oct 8</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Oct 8</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>saw</u> the body after death.									
22b. SIGNATURE <u>Wayne Spiggle</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Oct 9/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WAYNE SPIGGLE, MD						22e. ADDRESS BMG-912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-11-85		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Inglesmith Bedford Penna.		
24. FUNERAL DIRECTOR NAME Silcox-Merritt 404 Decatur St., Cumb., Md. 21502						25a. DATE REC'D. BY REGISTRAR OCT 14 1985		25b. REGISTRAR'S SIGNATURE <u>John A. ...</u>	

301093

RAOLD

AUSTIN

ECLEY

OCTOBER 1, 1963

1:00P

ALLIANCE COUNTY

SACRED HEART HOSPITAL

217-10-1458



X

WAYNE SPIEGLE, MD

W-312 SETON DRIVE, CUMBERLAND, MD 21502

OCT 1 4 1963

305138

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the funeral director's office within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicare examiner must be notified.

MEDICAL CERTIFICATION

SCARPELLI FUNERAL HOME				STATE OF MARYLAND			
1. FOR STATE REGISTRAR 108 VIRGINIA AVE., CUMBERLAND, MD 21602				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
(Helen) (Pauline) PAULINE HELEN BOYCE				OCTOBER 22, 1985			
3 SEX		4 RACE		5. DATE OF BIRTH		2b. HOUR	
female		white		03-23-1912		8:30 A <sub>M</sub>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY)	
WV		USA				73 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH			
Cumberland		SACRED HEART HOSPITAL		ALLEGANY COUNTY MD			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
housewife		own home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		Allegany		Frostburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
Arthur D. Boyce		Minnie L. Harris		100 Honeysuckle Lane/21532			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		235 52 7468		Lourn M. Boyce, Frostburg, MD -brother			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>ARTERIOSCLEROTIC HEART DISEASE, CONGESTIVE HEART FAILURE</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 11</u> , 19 <u>85</u> , to <u>OCT 22</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>OCT 21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>S. Chang M.D.</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
SATURINA CHANG, MD				FROSTBURG PLAZA, FROSTBURG, MD 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		10-25-1985		Queens Point Cemetery		Keyser Mineral WV	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				OCT 28 1985		<u>John L. ...</u>	

BP

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PAULINE HELLM VOICE  
OCTOBER 22, 1982 8:30 A

ALLEGANY COUNTY

SACRED HEART HOSPITAL

ST. JOSEPH'S



SATURDAY, OCTOBER 22, 1982

Handwritten signature and date: 10/22/82

297090

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 3 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (Last, first, middle) <b>CECIL WESLEY BROADWATER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 17, 1985</b>		2b. HOUR MIN. <b>9:56 p.m.</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 9, 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>59</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Broadwater</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabella Knox</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-30-0277</b>		17. INFORMANT ADDRESS <b>Rosa Haines Cumberland, MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation - MI</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CAD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. H. C. Merrick</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. H. C. Merrick</b>						22e. ADDRESS <b>500 Memorial Ave., Memorial Med. Bldg. Cumberland, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Oct. 21, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. P.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg Allegany MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>William G. Kight Cumberland, MD</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 22 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Delia F. Anderson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

Male	White	Mar. 9, 1926	29
MD	USA	xx	Allegany
MD	Allegany	Cumberland XX	213 Davidson St. 21502
John	Broadwater	Isabella	Knox
No	Rosa Haines	Cumberland, MD	

William G. Knight Cumberland, MD  
Oct 21, 1925 Frostburg Mem. P. Frostburg Allegany MD



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

8 5 2 6 9 3 1

REG. NO

16b WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b SOCIAL SECURITY NO. 216-22-6234	17 INFORMANT Mrs. Mildred L. Athey, LaVale, MD - daughter	ADDRESS
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

16a. DATE OF OPERATION	16b. CONDITION FOR WHICH OPERATION WAS PERFORMED	70a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)
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21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN	COUNTY	STATE
WHILE AT WORK	<input type="checkbox"/>	NOT WHILE AT WORK	<input type="checkbox"/>	[AT HOME STREET FACTORY, OFFICE, FARM, ETC.]	STREET			

22a I certify that (this hospital) information received from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that (I) (we) last  
saw (the) decedent alive on \_\_\_\_\_, 19\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated  
above. I (we) (us) certify the body after death \_\_\_\_\_

27b. SIGNATURE [Signature] DEGREE MD ATTENDING ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
Dr. Terry Williams	Medical Building Memorial Hospital Cumberland Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	10-05-1985	Sunset Memorial Park	Cumberland	Allegany	MD

24. FUNERAL DIRECTOR  
NAME James F. Scarpelli, Cumberland, MD 21502  
ADDRESS

BP\_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

DHMH - 16 60M 7/84  
(VRA 15, 4)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JESSIE MARKEE BRUNK</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>27</b> YEAR <b>85</b> 2b. HOUR <b>9</b> PM		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>13</b> YEAR <b>95</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>W. Va.</b>		13b. COUNTY <b>Mineral</b>	13c. CITY OR TOWN <b>Keyser</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>---</b> LAST <b>Cheshire</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>---</b> LAST <b>Starnes</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Mary Lupien, 1909 Maxwell Ave. Baltimore</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinomatous</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of colon</b>		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **---**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/5</b> , 19 <b>85</b> , to <b>11/24</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11/24</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Shrestha</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S.M. SHRESTHA</b>		22e. ADDRESS <b>The Memorial Hospital Cumberland, Md. 21502</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10/29/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Near Romney, Hampshire, WV.</b>
24. FUNERAL DIRECTOR <b>Harold W. McKenzie</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1985</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodgers</b>	

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OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS

U.S. DEPARTMENT OF COMMERCE

U.S. DEPARTMENT OF COMMERCE



U.S. DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
WASHINGTON, D.C.



303062

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>MARION Kay CASTLE</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>24</b> Year <b>85</b>			2b. HOUR <b>11:02</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>WIC</b>		5. DATE OF BIRTH <b>03/26/1899</b>		6. AGE (In years lost birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.				
10. CITY OR TOWN OF DEATH <b>LONA CONING</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ECLE NURSING HOME 57 JACKSON ST. LONA CONING HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>OWN HOME</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>LONA CONING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>14 W. RAILROAD ST. 9</b>	
14. FATHER'S NAME First Middle Last <b>WILLIAM ANDERSON</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MINERVA MILLER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>220-10-2166</b>		17. INFORMANT <b>Raymond Castle</b>			Address <b>14 W. R.R. ST. LONA CONING MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that (I) (this hospital) attended the deceased from <b>10/14/85</b> , 19 <b>82</b> , to <b>10/24/85</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>10/14/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Donald Manger MD</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10/24/85</b>				
22d. PHYSICIAN'S NAME (Type) <b>DONALD MANGER</b>			22e. ADDRESS <b>55 JACKSON ST LONA CONING</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-28-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Moscow Allegany Md</b>			
24. FUNERAL DIRECTOR <b>Eichhorn Funeral Home, Lonaconing, Md</b>						25a. REC'D BY REGISTRAR <b>DATE OCT 28 1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Anderson</b>		

303005

CHICKEN CO. 1948

CHICKEN CO. 1948



CHICKEN CO. 1948



296163

FOR  
1. STATE  
REGISTRATION

SOWERS FUNERAL HOME  
60 W MAIN STREET  
CUMBERLAND, MD 21113

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

2 6 9 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM LEE CHAMP</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 6, 1985</b>		2b. HOUR <b>6:30 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3/5/20</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.						
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>SPRINGFIELD KELLY TIRE</b>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>GROVER CHAMP</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SADIE VAN METER</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II 232 26 3375</b>		17. INFORMANT <b>TERRACE, CUMBERLAND, MD</b> <b>MRS. VERONICA FRIEND, 29 RIDGEWAYA</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypovolemic shock</b>						
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive upper G.I. Bleeding</b>						
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Stress ulcer or erosive gastritis</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Anti-coagulant therapy; recurrent CVA with left hemiplegia; Carotid stenosis</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (the hospital) attended the deceased from <b>9-28-85</b> , 19 <b>85</b> , to <b>10-6</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>10-6-</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.						
22b. SIGNATURE <b>S. Sandhir</b>		DEGREE <b>M.D., F.R.C.S.</b>		22c. DATE SIGNED <b>10-7-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. SANDHIR, MD</b>		22e. ADDRESS <b>48 TARN TERRACE, FROSTBURG, MD 21532</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/9/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ECKHART ALLEGANY MD</b>		23e. DATE REC'D. BY REGISTRAR <b>OCT 21 1985</b>				
24. FUNERAL DIRECTOR NAME <b>Walter M. Sowers</b>		ADDRESS <b>60 W. MAIN ST. FROSTBURG</b>		25. REGISTRAR'S SIGNATURE <b>J. H. ...</b>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

CHAP

OCTOBER 1982

ACE:3

312022

BOALS FUNERAL HOME

STATE OF MARYLAND

FOR STATE REGISTRAR  
111 CHURCH STREET  
WESTERNPORT, MD 21562

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELSIE MAE CLARK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 24 85</b>		2b. HOUR <b>12:15 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 7 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>House</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Barton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Morgan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Timney</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213744155</b>		17. INFORMANT ADDRESS <b>Mr. Robert Clark Barton Md. 21521</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metabolic Encephalopathy, Cardiac Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diagnosed Epilepsy</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Adnexa, Pyroptosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) told (did not) view the body after death.								
22b. SIGNATURE <b>S. KIM, M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10-27-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Mem. Gardens</b>		
24. FUNERAL DIRECTOR NAME <b>Wayne Boulton</b> ADDRESS <b>Boals Funeral Service Westernport, Md. 21562</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 04 1985</b>		
				25b. REGISTRAR'S SIGNATURE <b>John T. ...</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

312023

BOAL'S FURNACE HOME  
111 CHURCH STREET  
WESTPORT, MD 21562

ELISE MAE CLARK 10 24 82 12:12 P.M.

9 7 1900  
xx  
SACRED HEART HOSPITAL  
x  
21562  
21562



2. KIM, M.C.  
80 MAIN STREET, WESTPORT, MD 21562  
10-1-1  
Westport, Md. 21562

318032

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 4 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NELLIE ALBERTHA CLOSE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 31, 1985</b>		2b. HOUR <b>7 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12/12/1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>75</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH.</b> <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Ellerslie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Shroyer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Clites</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213-22-3058</b>	
17. INFORMANT ADDRESS <b>Clifton Close, Box 247, Ellerslie, MD 21529</b>		18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CAI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. HER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 3. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)		PART 4. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)			
19a. DATE OF OPERATION <b>Oct. 27 85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Sept. 27 85</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Oct. 27 85</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Nov. 31 85</b>			
22a. SIGNATURE <b>Dr. Terry Williams</b>		DEGREE <b>MD</b>		22b. ADDRESS <b>Memorial Hospital Medical Bldg. Cumberland, MD 21502</b>		22c. DATE SIGNED <b>11-3-85</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/4/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Palo Alto Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RD, Hyndman, Bedford, PA</b>	
24. FUNERAL DIRECTOR <b>Harvey H. Zeigler</b>		ADDRESS <b>Hyndman, PA 15545</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia K. ...</b>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove it from this document. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

318092

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

294110

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CUMBERLAND, MD 21502										8 5 2 6 9 4 3			
FOR 1- STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CHESTER ROBERT COLLINS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 8, 1985</b>					2b. HOUR <b>12:29 P</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-23-1918</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>							
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad/Glass</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>16 Long Drive/21502</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wilkie Collins</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Potts</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW II</b>		17. INFORMANT <b>Mrs. Rebecca Collins, Cumberland, MD - wife</b>		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>The fastapic Carcinoma of the Colon</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Small bowel obstruction</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>8/31</b> , 19 <b>85</b> , to <b>10/8</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10/7</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <b>Richard H. Snider MD</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD SNIDER, MD</b>					22e. ADDRESS <b>P.O. BOX 2455 CUMBERLAND, MD 21502</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-11-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Gap Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Flintstone Allegany MD</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>James F. Scarpelli, Cumberland, MD 21502</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1985</b>					25b. REGISTRAR'S SIGNATURE <b>John E. ...</b>			

001110

CHESTER

ROBERT

CUTTING

OCTOBER 2, 1968

12:38 P

ALBANY COUNTY

SACRED HEART HOSPITAL

708-05-2304

RICHARD SHIDER, MD

P.O. BOX 2455 CUMBERLAND, MD 21502

305153

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 4/83  
(VRA 15, 4)FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CARLEN JAMES CRISLIP			2a. DATE OF DEATH MONTH DAY YEAR October 23, 1985		2b. HOUR 11:21A
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 5, 1911	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
12. CITY OR TOWN OF DEATH Cumberland	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor	15. KIND OF BUSINESS OR INDUSTRY Railroad	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE PA			16b. CITY OR TOWN Bedford	16c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17. FATHER'S NAME FIRST MIDDLE LAST Arthur B. Crislip			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Allie Gertrude Watkins		
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 211 07 7224	20. INFORMANT ADDRESS Mary E. Crislip, Box 202, Hyndman, PA 15545		
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>					
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED		22c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
24a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		24c. LOCATION STREET CITY OR TOWN COUNTY STATE	
25. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 19 <u>85</u> , to <u>10/23</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>10/23</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
26. SIGNATURE <i>W. H. Elcher</i>		DEGREE MD		27. DATE SIGNED 10/23/85	
28. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William James		29. ADDRESS 441 N. Centre Street, Cumberland, MD 21502			
30. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	31. DATE 10/26/85	32. NAME OF CEMETERY OR CREMATORY Lybarger Cemetery	33. LOCATION CITY OR TOWN COUNTY STATE Londonderry Twp, Bedford, PA		
34. FUNERAL HOME <i>Harvey H. Zeigler</i>		35. DATE REC'D. BY REGISTRAR OCT 28 1985	36. REGISTRAR'S SIGNATURE <i>John Davidson Rode</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18, item 21 is marked as item 18.)

BP

302123

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305142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

MEDICAL CERTIFICATION

BOALS FUNERAL HOME				STATE OF MARYLAND		8 5 2 6 9 4 5	
1. FOR REGISTRATION 111 CHURCH STREET WESTERNPORT, MD. 21562				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
REG. NO.				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUTHER WILLIAM CRITES				2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 22, 1985		2b. HOUR 10:00 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 10 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Westvaco		12b. KIND OF BUSINESS OR INDUSTRY Paper	
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Luke	
14. FATHER'S NAME FIRST MIDDLE LAST Noah Martin Crites				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madaline Wolf			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-05-0418		17. INFORMANT ADDRESS Mrs. Blanche Crites Luke, Md. 21540			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTRACTABLE CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE &amp; VENTRICULAR ARRHYTHMIA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CHRONIC LUNG DISEASE, RENAL FAILURE</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 20</u> , 19 <u>85</u> , to <u>Oct 22</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Oct 22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>S Chang M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S Chang M.D.</u>				22e. ADDRESS <u>FROSTBURG PLAZA FROSTBURG MD 21532</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-25-85		23c. NAME OF CEMETERY OR CREMATORY Potomac Memorial Gard.		23d. LOCATION KEYSER MINERAL CO. West Virginia	
24. FUNERAL DIRECTOR Boals Funeral Service Westernport, Md. 21562				25a. DATE REC'D. BY REGISTRAR OCT 28 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

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ALLEGANY COUNTY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 2 6 7 4 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRVIN GEORGE DARR				2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 3, 1985		2b. HOUR 2:07 <sup>P</sup> M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 30 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 217-10-5604		17. INFORMANT ADDRESS Mrs. Grace Darr - Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Poorly Differentiated Carcinoma of the Lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>85</u> , to <u>Oct 3</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Oct 3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Paul Livengood MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Oct 4, 1985</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL LIVENGOOD, MD				22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/4/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 16 1985	
				25b. REGISTRAR'S SIGNATURE <u>Julia Linder</u>			

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DATE

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WILSON COUNTY

SACRED HEART HOSPITAL



ONE 812 SETON DRIVE, CUMBERLAND MD 21502

FRUL LIVERPOOL MD

10/10/48

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 4 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>CHARLES RAY DAVIS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>October 13, 1985</b>			2b HOUR <b>1:20<sup>a</sup> M</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 6, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10 CITY OR TOWN OF DEATH <b>Cumberland</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner-Plumbing &amp; Heating Co.</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Maryland</b>		13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Cumberland</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>14 Marion Street / 21502</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Clarence - Davis</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(Unknown)</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-34-1487</b>		17 INFORMANT ADDRESS <b>511 Prince Geo. St. Cumberland, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Heart failure - severe</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>									
19a DATE OF OPERATION <b>10/1/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Tachemia Right Leg</b>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>10/13/85</b>					
22a I certify that (I) (this hospital) attended the deceased from <b>8/1/85</b> to <b>10/13/85</b> that (I) (we) last saw the deceased alive on <b>10/12/85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Richard T. Snider</b>				DEGREE <b>Dr.</b>		22c. DATE SIGNED <b>10/13/85</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Richard Snider</b>				22e ADDRESS <b>The Memorial Hospital Medical Bldg. Memorial Ave., Cumberland, Md. 21502</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>10-15-85</b>		23c NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland-Allegany CO.-Md.</b>			
24 FUNERAL DIRECTOR NAME <b>George-Upchurch Funeral Home, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>Oct 21 1985</b>		25b. REGISTRAR'S SIGNATURE			
202 Greene Street, Cumberland, Md. 21502									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL MAY DEAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 7, 1985</b>			2b. HOUR <b>11:10A.</b>				
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-20-1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>128 Seymour Street/21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Terry Williams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Samuel L. Linn</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-22-7023</b>		17. INFORMANT ADDRESS <b>Mr. Milford J. Dean, Cumberland, MD - son</b>						
18. CAUSE OF DEATH (Enter only one cause per line) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Acute aortic + chronic CHF</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>CAD + obstructive pulmonary</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.									APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 4, 1985</b> to <b>Oct 7, 1985</b> , that (I) (we) last saw the deceased alive on <b>Oct 4, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death.)										
22b. SIGNATURE <b>Williams</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>			22c. DATE SIGNED <b>10-7-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. T. WILLIAMS</b>			22e. ADDRESS <b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-10-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>			
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, MD 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1985</b>				
25b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>										

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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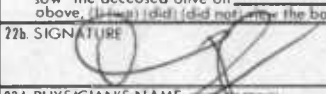
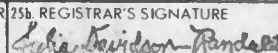


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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HAVER FUMERAL HOME 1302 NATIONAL HWY. LAVALE, MD. 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELIZABETH MALCOLM DUKE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 15, 1985</b>		2b. HOUR <b>01:30A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 5, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>74</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>LaVale</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Munro</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Mae Corfield</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4 N. Woodlawn Ave./21502</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-10-5369</b>		17. INFORMANT ADDRESS <b>Henry K. Duke - same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced Metastatic G. h</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Primary Proh. Colon</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (I) (did) (did not) (sign the body after death).							
22b. SIGNATURE 		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/15/85</b>	
22d. PHYSICIAN'S NAME <b>DR. QAMAR ZAMAN, M.D.</b>		22e. ADDRESS <b>MEMORIAL MEDICAL BLDG., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/18/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Alleg., MD</b>	
24. FUNERAL DIRECTOR NAME <b>John J. Hafer, Jr. LaVale, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 18 1985</b>		25b. REGISTRAR'S SIGNATURE 	

BP \_\_\_\_\_



289052

1- FOR  
STATE  
REGISTRARSCARPELLI FUNERAL HOME  
108 VIRGINIA AVE. DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CUMBERLAND, MD. 21502 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PAUL LANTZ EVANS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 5, 1985</b>			2b. HOUR <b>02:55A M</b>				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08-09-1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>WV</b>		13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Ft. Ashby</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Box 346/26719 99999</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oscar L. Evans</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hettie Dawson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean</b>		17. INFORMANT <b>Esther V. Evans, Ft. Ashby, WV - wife</b>		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Laennec's Cirrhosis of Liver</b>								DUE TO, OR AS A CONSEQUENCE OF		
(c)								DUE TO, OR AS A CONSEQUENCE OF		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/4 85</b> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>10/5 85</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>10/4 85</b> to <b>10/5 85</b> , that (I) (we) lost <b>10/5/85</b> saw the deceased alive only above (I/we) did (did not) view the body after death.										
22b. SIGNATURE <b>Andrew Stasko</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/5/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ANDREW STASKO, M.D.</b>			22e. ADDRESS <b>924 SETON DR., CUMBERLAND, MD. 21502</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-07-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Ashby Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fort Ashby Mineral WV</b>			
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, MD 21502</b>			ADDRESS <b>99999</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 9 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

250025



100

SCOTT'S BOTTLED WATER  
100 VINTAGE AVE.  
CHATELAIN, MO. 250025

DATE

OCTOBER 2, 1982

STAMP

TIME

WALL

WILSON COUNTY

BRIDGE HALL HOSPITAL

250-33-6268

100 VINTAGE AVE.

CHATELAIN, MO. 250025



250 SOUTH 100 CHATELAIN, MO. 250025

DR. WILSON COUNTY, MO.



311171

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 5 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELINOR BOYD FINK			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 28, 1985			2b. HOUR 11:21P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 24, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 612 Crest Drive / 21502			14. FATHER'S NAME FIRST MIDDLE LAST Julian Thruston Boyd			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elinor - Shriver				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - 217-10-1903		17. INFORMANT ADDRESS Barbara Roque-Address same as #13 above.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE ISCHEMIC CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a DIABETES MELLITUS ; SJOGREN'S SYNDROME APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 10-28 to 19 85 that (I) (we) last saw the deceased alive on 10-28 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (did not) saw the body after death.										
22b. SIGNATURE DR. TORRES			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			MEMORIAL HOSPITAL			MEDICAL BUILDING			21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-31-85		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland - Allegany - Md.			
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502			25a. DATE REC'D. BY REGISTRAR NOV 05 1985			25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEONARD JOSEPH GARLITZ			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 28, 1985			2b. HOUR 6:00 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 13 22		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) --		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE Frostburg Heights #G-9 21532			14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 92 1031			17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced Carcinoma of Esophagus</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Esophageal pleural effusions</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>possible metastatic tumor from Adeno Ca of Esophagus</i>										
19. DATE OF OPERATION			19a. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 4</i> 19 <i>85</i> to <i>Oct 28</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>Oct 28</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE <i>Chang Oh, MD</i>			DEGREE MD			22b. DATE SIGNED <i>Oct 28 85</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (TYPE OR PRINT) CHANG OH, MD			22d. ADDRESS 48 TARN TERRACE, FROSTBURG, MD 21532							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 10/29/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR 6 1985		25b. REGISTRAR'S SIGNATURE <i>J. L. Davidson</i>	

MEDICAL CERTIFICATION

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this to the Registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNIT

RECEIVED NOTION 2007

LEARNED WEEKS 04/11/07 04/11/07 04/11/07

ST. JOHN'S HOSPITAL

1001 00 1001

AS TARI TERRACE, PROSTATE, 10 2007

ONE ON NO

304211

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 5 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>REDA MAE GROSS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 16, 1985</b>			2b. HOUR <b>6:05A.</b> M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/20/08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>76</b>		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD				
12. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		
16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>WV</b>			13b. COUNTY <b>Morgan</b>		13c. CITY OR TOWN <b>Paw Paw</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>P.O. Box 194 25434</b>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Hutson</b>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sadie A. Jamison</b>							
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			19b. SOCIAL SECURITY NO. <b>233-70-9196</b>		17. INFORMANT ADDRESS <b>Carson Gross, P.O. Box 194, Paw Paw, WV 25434</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHTimePART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>10-8</u> 19 <u>85</u> to <u>10-16</u> 19 <u>85</u> that (1) (we) lost saw the deceased alive on <u>10-15</u> 19 <u>85</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.							
22b. SIGNATURE <u>Anthony Bollino</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>17 Oct 85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ANTHONY BOLLINO</b>				22e. ADDRESS <b>955 Frederick St. Cumberland, Maryland 21502</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/19/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Camp Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Paw Paw, Morgan, WV</b>	
24. FUNERAL DIRECTOR NAME <b>Helsley-Johnson F.H.</b>				25a. DATE REC'D. BY REGISTRAR <b>10/21/85</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30151

100% COTTON FIBER

WHITE WA DOW



305137

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be the duty of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for post mortem examination.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 2 6 9 5 4			
SCARPELLI FUNERAL HOME 108 VIRGINIA AVE CUMBERLAND, MARYLAND				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA LEE HANSROTH				2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 24, 1985		2b. HOUR 09:00AM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-20-1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James M. Harness		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ann McNeill		13e. STREET ADDRESS / ZIP CODE 51 Browning Street/21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 820-06-3459		17. INFORMANT ADDRESS Miss Shirley L. Hansroth, Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile Dementia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>old Multiple Cerebral Vascular Accidents</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 21</u> 19 <u>85</u> , to <u>Oct 24</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Oct 23</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Paul J. Livengood MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul T. Livengood, M.D.				22e. ADDRESS BMG, 912 SETON DR., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-26-1985		23c. NAME OF CEMETERY OR CREMATORY Maple Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Petersburg Grant WV	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR OCT 28 1985			
				25b. REGISTRAR'S SIGNATURE <u>John Davidson Rondello</u>			

302137

SCARLETT FUSAL HOME  
102 VIRGINIA AVE  
CAMBRIDGE, MASSACHUSETTS

VIRGINIA LEE TWEED

OCTOBER 25, 1982

09:00

ALLEGANY COUNTY

SACRED HEART HOSPITAL



RECEIVED  
OCTOBER 25 1982

Handwritten notes and signatures, including a large 'X' and various illegible scribbles.

ENC. 812 SECTION DE. CAMBRIDGE, MASS. 02142

Handwritten notes at the bottom left corner.



297031

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

NEWMAN FUNERAL HOME 1. STATE REGISTRAR PO BOX 267 GRANTSVILLE, PA 21536				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 2 6 9 5 5			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
WILLIAM EDWARD HARMAN				OCTOBER 8, 1985				19:54 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 72 HRS	
Male		White		June 12, 1915		70 YRS		MONTHS DAYS		HOURS MIN.	
9. BIRTHPLACE		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED		12. BALTIMORE CITY OR COUNTY OF DEATH		13. USUAL OCCUPATION		14. KIND OF BUSINESS OR INDUSTRY	
Maryland		USA		WIDOWED		ALLEGANY COUNTY, MD.		Wildlife Super.		MD DNR	
15. CITY OR TOWN OF DEATH		16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		17a. USUAL RESIDENCE		17b. STREET ADDRESS / ZIP CODE		18. INSIDE CITY LIMITS?		19. STREET ADDRESS / ZIP CODE	
Cumberland		SACRED HEART HOSPITAL		Maryland		Route 2, Box 25, 21520		YES		NO	
10. FATHER'S NAME		11. MOTHER'S MAIDEN NAME		12. INFORMANT		13. SOCIAL SECURITY NO.		14. DATE OF OPERATION		15. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Henry Harman		Anna Georg		Helen L. Harman, Accident, MD		217-16-4293		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. STREET ADDRESS / ZIP CODE		18. INSIDE CITY LIMITS?		19. STREET ADDRESS / ZIP CODE		20. DATE OF OPERATION	
Yes		217-16-4293		Route 2, Box 25		YES		21. STREET ADDRESS / ZIP CODE		22. DATE OF OPERATION	
18. CAUSE OF DEATH		19. SOCIAL SECURITY NO.		20. STREET ADDRESS / ZIP CODE		21. INSIDE CITY LIMITS?		22. STREET ADDRESS / ZIP CODE		23. DATE OF OPERATION	
PART I. DEATH WAS CAUSED BY:		217-16-4293		Route 2, Box 25		YES		24. STREET ADDRESS / ZIP CODE		25. DATE OF OPERATION	
IMMEDIATE CAUSE (a)		217-16-4293		Route 2, Box 25		YES		26. STREET ADDRESS / ZIP CODE		27. DATE OF OPERATION	
Consecutive Heart Failure		217-16-4293		Route 2, Box 25		YES		28. STREET ADDRESS / ZIP CODE		29. DATE OF OPERATION	
DUE TO, OR AS A CONSEQUENCE OF		217-16-4293		Route 2, Box 25		YES		30. STREET ADDRESS / ZIP CODE		31. DATE OF OPERATION	
Chronic Obstructive Pulmonary Disease		217-16-4293		Route 2, Box 25		YES		32. STREET ADDRESS / ZIP CODE		33. DATE OF OPERATION	
DUE TO, OR AS A CONSEQUENCE OF		217-16-4293		Route 2, Box 25		YES		34. STREET ADDRESS / ZIP CODE		35. DATE OF OPERATION	
Chronic Obstructive Pulmonary Disease		217-16-4293		Route 2, Box 25		YES		36. STREET ADDRESS / ZIP CODE		37. DATE OF OPERATION	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		217-16-4293		Route 2, Box 25		YES		38. STREET ADDRESS / ZIP CODE		39. DATE OF OPERATION	
Chronic Obstructive Pulmonary Disease		217-16-4293		Route 2, Box 25		YES		40. STREET ADDRESS / ZIP CODE		41. DATE OF OPERATION	
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. DATE OF OPERATION		21e. CONDITION FOR WHICH OPERATION WAS PERFORMED		21f. DATE OF OPERATION	
OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. 19				19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
WHILE AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
NOT WHILE AT WORK						19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
22. I certify that (I) (this hospital) attended the deceased from		22a. DATE OF OPERATION		22b. DATE OF OPERATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
above (I) (we) (did) (did not) view the body after death.		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION		19d. CONDITION FOR WHICH OPERATION WAS PERFORMED		19e. DATE OF OPERATION	
22c. SIGNATURE		22d. DEGREE		22e. DATE SIGNED		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
Chang Oh, MD		ATTENDING PHYSICIAN		Oct 9, 85		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
22f. PHYSICIAN'S SIGNATURE		22g. ADDRESS		22h. DATE SIGNED		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
Chang Oh, MD		48 TARN TERRACE, FROSTBERG, MD 21532		Oct 9, 85		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. DATE OF OPERATION	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE RECD. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Burial		10-11-85		Zion Lutheran Cemetery		Accident, Garrett, MD		Oct 11, 1985		Ali L. L. L. L. L.	
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. DATE RECD. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		24d. DATE RECD. BY REGISTRAR		24e. REGISTRAR'S SIGNATURE	
A. Newman		Grantsville, MD		Oct 11, 1985		Ali L. L. L. L. L.		Oct 11, 1985		Ali L. L. L. L. L.	

27-601

NEWBY FUNERAL HOME  
PO BOX 267  
GRANTSVILLE, PA 21536

THOMAS NEWBY  
GRANTSVILLE, PA 21536

WILLIAM EDWARD HANMAN  
OCTOBER 8, 1982  
1915

ALLBURY CO. INC.

SACRED HEART HOSPITAL

217-16-4593



202 COLUMN 18E

DEFERRED

18 TOWN TERRACE, FROSTBURG, MD 21532

CHANG CH. NO

REG. NO.

## MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filled within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal. Important: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

30113

12:15 P  
OCTOBER 19, 1982  
HASELBERGER  
SUSAN  
MILLIE

ALLIANCE COUNTY  
SACRED HEART HOSPITAL  
218-78-3922



THE 912 SECTOR DRIVE CAMPBELL, CA 95803

317074

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 11. IN ITEM 11, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Evelyn P. Holmes</b>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>10</b> DAY <b>30</b> YEAR <b>1985</b>				2b. HOUR <b>3:41</b> M	
3. SEX <b>F</b>		4. RACE <b>W</b>		DATE OF BIRTH MONTH <b>SEPT.</b> DAY <b>18</b> YEAR <b>1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FROSTBURG COMMUNITY HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST <b>ALBERT</b> MIDDLE LAST <b>PLUMMER</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MAUDE</b> MIDDLE LAST <b>RICHARDS</b>				17. INFORMANT ADDRESS <b>JAMES M. HOLMES SAME AS 13E</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>214-07-3756</b>				17. INFORMANT ADDRESS <b>JAMES M. HOLMES SAME AS 13E</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition due to</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>prolongued anorexia. - possible</b> (b) <b>C.A.</b> (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Francisco Reyes</b>				TITLE (SPECIFY) <b>Deputy</b> M.D.				DATE SIGNED <b>10-30-85.</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Francisco Reyes</b>				ADDRESS <b>900 Seton Dr. Cumberland, Md 21502</b>					
23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>Nov. 2, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FROSTBURG ALLEGANY MD.</b>	
24. FUNERAL DIRECTOR NAME <b>DURST FUNERAL HOME, FROSTBURG, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 6 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Twyman</b>			

315084

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

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U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

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U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535





304192

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 5 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ETHEL ISABEL JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 21, 1985			2b. HOUR 9:45A. M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 19 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS IN REST.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 507 1/2 FRANKLIN STREET 21502	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES H. WRIGHT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELLA KORNS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-36-9006		17. INFORMANT ADDRESS HOWARD FRICKEY 402 BEALL ST CUMBERLAND MD.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cream Negative Bacteremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arterio sclerotic Heart Disease, CHF</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-17</u> 19 <u>85</u> to <u>10-21</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>10-21</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. J. Barrera, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>10-21-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BARRERA						22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT 24 1985		23c. NAME OF CEMETERY OR CREMATORY ROSEHILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.			
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.						25a. DATE REC'D. BY REGISTRAR OCT 24 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 and 21 are marked, the medical examiner must be notified of the event.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



295162

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 5 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE CATHERINE LAST JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 9, 1985			2b. HOUR A M 7:54	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT 11 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITALS MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Litten		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Mooney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-20-6156		17. INFORMANT ADDRESS Mrs. Mary Ann Ault, Cumberland, MD-daughter			
18. CAUSE OF DEATH: (Enter only one cause per line for terminal disease or condition.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest Advanced ASCVD CVA + PE DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Aortic Aneurysm							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Sept. 13 85 to Sept 24 85			
22a. I certify that (1) (this hospital) provided medical and nursing care for the deceased alive on (date) and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not touch the body after death.							
22b. SIGNATURE Chellum W		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-10-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J E Williams, MD		22e. ADDRESS Memorial Hospital, Cumberland, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-14-1985		23c. NAME OF CEMETERY OR CREMATORY Rocky Gap Cemetery		23d. LOCATION (CITY OR TOWN) COUNTY STATE Flintstone Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 15 1985 John David Riddle			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

Don't panic  
S.O. H. H. H.  
IV-3 IV-5

282113

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 7 6 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARJORIE V. JUDY			2a. DATE OF DEATH MONTH DAY YEAR October 2, 1985		2b. HOUR 12:54 AM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN West Virginia Mineral Ft. Ashby						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 28 / 26719			
14. FATHER'S NAME FIRST MIDDLE LAST Jacob A. Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jamie = Biser							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 233-96-1475		17. INFORMANT Herbert Judy - Ft. Ashby, West Virginia							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Liver failure - metastases</i>		14 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Septicemia</i>		3 days	

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

*Cancer of rectum*

19a. DATE OF OPERATION 9/18/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer - rectum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from Sept, 19 85, to Oct. 2, 19 85, that (I) (we) last saw the deceased alive on Oct. 2, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Thomas J. Lewis MD		DEGREE		22c. DATE SIGNED 10/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thomas Lewis		22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-4-85		23c. NAME OF CEMETERY OR CREMATORY Ft. Ashby Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Ashby-Mineral-West Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR OCT 7 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rossell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

999994

811383

20% COTTON FIBER



304212

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST RICHARD		MIDDLE Lee		LAST KERNS		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 10		DAY 20		YEAR 85		HOUR 1130	
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR July 4, 1946		6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 20 85		12a. HOUR 1205			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH PLACE, GIVE STREET ADDRESS) 13 E. Industrial Blvd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attendant				12b. KIND OF BUSINESS OR INDUSTRY Service Station					
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13 East Industrial Blvd 21502							
14. FATHER'S NAME FIRST MIDDLE LAST John F. Kerns								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen M. Renninger									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 21 9-44-0218				17. INFORMANT ADDRESS Mr. Gary E. Kerns, Cumberland, Md. Brother									
18. CAUSE OF DEATH (Enter only one cause preceding (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Artery</u> <u>Coronary Heart Disease</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Chronic alcohol abuse</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>Paul Snow</i>				M.D. Paul Snow, M.D.				MEDICAL EXAMINER DATE SIGNED 10-20-85									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS Memorial Hospital, Cumberland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-22-1985				23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery				23d. LOCATION (CITY OR TOWN) COUNTY STATE Near Chaneyville, Pa.					
24. FUNERAL DIRECTOR NAME James F. Scarpella				ADDRESS Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR OCT 24 1985				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

304213

NOTICE  
MILITARY



*[Handwritten signature]*

310025

FOR  
1. STATE  
REGISTRAR

DURST FUNERAL HOME  
57 FROST AVE,  
FROSTBURG, MD 21532

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 6 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR LEROY KIRBY			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 22, 1985		2b. HOUR 9:30 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 10, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Appliances	
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. STREET ADDRESS / ZIP CODE 53 Meshach Frost Village 21532		

14. FATHER'S NAME FIRST MIDDLE LAST Joseph P. Kirby			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linnie Leasure		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-1917		17. INFORMANT ADDRESS Vauda B. Kirby, Frostburg, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>AS KID</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 years</u>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Emphysema, vertebral fracture, eczema

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOI WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>George M. Breza MD</u>		DEGREE		22c. DATE SIGNED 10-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George M. Breza, M.D.		22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 24, 1985		23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Savage, Allegany, Md.	
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24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		25a. DATE REC'D. BY REGISTRAR OCT 29 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Peters</u>	
--	--	--	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

810032

GURST FUNERAL HOME  
27 FIRST AVE.  
FROSTBURG, MD 21232

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTRAL RECORDS DIVISION

ARTHUR LEROY KIRBY  
OCTOBER 22, 1922  
9:50 A.  
ALLGAIN COUNTY  
SACRED HEART HOSPITAL  
FROSTBURG, MARYLAND  
JOSEPH P. KIRBY  
214-27-1017  
YONAH B. KIRBY, FROSTBURG, MD.



George H. Brock, M.D.  
THE 512 SEIG DRIVE, CUMBERLAND, MD 21502  
BRIAL : Oct. 24, 1985 Methodist Cemetery  
Mt. Savage, Allegany, Md.  
Gurst Funeral Home, Frostburg, Md.

289098

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BOALS FUNERAL HOME				STATE OF MARYLAND			
1- FOR 111 CHURCH STREET STATE REGISTRAR WESTERNPORT, MD 21562				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
REG. NO.				8 5 2 6 9 6 3			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MERLE HENRIETTA KYLE				2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 3, 1985			
3. SEX Female				2b. HOUR 9:00 AM			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 28 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY House	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Allegany			
13c. CITY OR TOWN Barton				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph W.. Callis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Wiland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 36 9539		17. INFORMANT ADDRESS Mr. Joseph Kyle Barton, Md. 21521			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cor. art. Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>S/P C.A.B.G., Diab. Mellitus, C.H.F.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> , 19 <u>85</u> , to <u>10/3</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>10/3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE <u>C. J. Vincent - M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <del>XXXXXXXXXX</del> BALJEET MAHAL, MD				22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 10-5-85		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Gardens		23d. LOCATION Cumberland Allegany Md. STATE	
24. FUNERAL DIRECTOR NAME <u>Wayne Bruff</u> ADDRESS Boals Funeral Service Westernport, Md. 21562				25a. DATE REC'D BY REGISTRAR OCT 8 1985		25b. REGISTRAR'S SIGNATURE <u>John Anderson</u>	





301028

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Arno E. Lambert</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 21, 1985</b>		2b. HOUR <b>8:00 p</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 13, 1912</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>Cresaptown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>13024 Sixth Avenue</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cresaptown</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sylvanus Lambert</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Lambert</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 217-10-6086</b>		17. INFORMANT ADDRESS <b>Irene Houser - Denver, PA 17517</b>		
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diseminated Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Spontaneous Lymphoma IV-B</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Emaciation - Cachexia</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/30/85</b> 19 <b>85</b> , to <b>10/21</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>9/12</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Dr. V. R. Felipa</b>		DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. V. R. Felipa</b>		22e. ADDRESS <b>925 Bishop Walsh Drive, Cumb, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/24/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Mem. Gard.</b>		
24. FUNERAL DIRECTOR NAME <b>John J. Hafer, Jr.</b>		ADDRESS <b>LaVale, MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale, Alleg., MD</b>		
25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>				

3010521

COPIES 1000

TO THE DIRECTOR, FBI

FROM THE SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE DIRECTOR, FBI

ADMINISTRATIVE

100-100000-1000

305104

FOR ZIEGLER FUNERAL HOME  
1- STATE HYDMAN, PA.  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EFFIE GERTRUDE LEE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 22, 1985</b>			2b. HOUR <b>3:00P<sub>M</sub></b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10/05/07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
13a. STATE <b>PA</b>			13b. COUNTY <b>Somerset</b>		13c. CITY OR TOWN <b>Wellersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter S. Rizer</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances L. Shaffer</b>			13e. STREET ADDRESS / ZIP CODE <b>Rt. 1, Box 272, Hyndman, PA 15545</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213245217</b>		17. INFORMANT ADDRESS <b>Roy Lee, Jr., Box 55, Wellersburg, PA 15564</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Congestive heart failure</i></u> DUE TO, OR AS A CONSEQUENCE OF (b) <u><i>ASCVD</i></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u><i>2 weeks</i></u> <u><i>15 years</i></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u><i>Hypertension and failure, stroke</i></u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u><i>George Breza M.D.</i></u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/23/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE BREZA, M.D.</b>				22e. ADDRESS <b>912 SETON DRIVE CUMBERLAND, MD. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/25/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wellersburg Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wellersburg, Somerset, PA</b>			
24. FUNERAL DIRECTOR <u><i>Harvey W. Zeigler</i></u>				25a. DATE REC'D. BY REGISTRAR <b>10/28/85</b>		25b. REGISTRAR'S SIGNATURE <u><i>[Signature]</i></u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event the medical examiner should be notified at once.

305104

ZIEGLER, EUGENE W. HOME  
HYONAN, PA.

HYONAN, PA.  
ZIEGLER, EUGENE W. HOME  
ZIEGLER, EUGENE W. HOME

3:00P OCTOBER 23, 1982 LEE GERTRUDE EFFIE

ALLEGANY COUNTY

SACKED HEART HOSPITAL

213245217

20% COTTON



312 SETON DRIVE CAMERLAND, MD. 21508

GEORGE W. BETA, M.D.

312009

STATE OF MARYLAND  
 1. FOR DURST FUNERAL HOME DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR 57 FROST AVE. FROSTBURG, MD. CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RONALD CARROLL LEWIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 27, 1985</b>		2b. HOUR <b>11:10 AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 26, 1937</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Trooper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Police</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt. 3, Box 174, 21532</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gerald Lewis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Houdershell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220380140</b>		17. INFORMANT ADDRESS <b>M. Rita Lewis, Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic coma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Alcohol abuse</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gary Wagoner MD</b>				DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10-28-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY WAGONER, M.D.</b>				22e. ADDRESS <b>925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 30 '85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Durst Funeral Home, Frostburg, Md.</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John E. Fowler</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach page 3, pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

312403

CURST PATENT FIRM

37 WEST AVE. FROSTBURG, MD.

ROMULO CARROLL LEWIS OCTOBER 27, 1932 ALABAMA

Wife Date Sept. 22, 1934

ALLSOUTH COUNTY

SACRED HEART HOSPITAL

St. Albans

Myrtle, Maryland, Frostburg

St. 2, Box 17, St. 2

Deville Lewis Rush

220381110 M. Rice Lewis, born in 190



NOTION CO. 20%

GARY WATSON, M.D. 252 HIGHT WALSH ROAD CLIMBRIAN, MD. 21502

Bristol Oct. 30, 1932 St. Michaels Con. Frostburg, Maryland, Md.

James Thomas, Jr., Frostburg, Md.



305149

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 5 2 6 9 6 1	
FOR ROTRUCK FUNERAL HOME		85 S. Main Street		CERTIFICATE OF DEATH	
1- REGISTRAR		Keyser, WV		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wanda Lee Liller			2a. DATE OF DEATH MONTH DAY YEAR October 21, 1985		2b. HOUR 5:15a M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --
13a. STATE W. Va.		13b. CITY OR TOWN Mineral	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE Rt 1 Box 221 26726	
14. FATHER'S NAME FIRST MIDDLE LAST Jack - Corbin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora F. Sears		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 234446787		17. INFORMANT ADDRESS Robert H. Liller Rt 1 Box 221 Keyser, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kelastatic Ca of breast</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>10-18</u> , 19 <u>85</u> , to <u>10-21</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10-20</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John Mehanna</u>		DEGREE M.D.		22c. DATE SIGNED 10-21-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Mehanna, M.D.		22e. ADDRESS 909-B Seton Drive, Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 24 Oct 1985	23c. NAME OF CEMETERY OR CREMATORY Cabin Run		23d. LOCATION CITY OR TOWN COUNTY STATE Fountain Mineral W. Va.
24. FUNERAL DIRECTOR NAME Allen Rotruck Keyser, W. Va.		ADDRESS		25a. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE OCT 28 1985 <u>John Rotruck Keyser</u>	

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Allen Norton Keyser, W.Va.

Serial 24 Oct 1955 Cabin Run

900-B State Drive, Charleston, W.Va. 25302

Mountain Mineral W.Va.

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X

Robert E. Miller Rt 1 Box 224 Keyser, W.Va.

Gold F. Bears

W. Va. Mineral Keyser X Rt 1 Box 224 25320

Camdenland Covered Road Hospital Homestead --

W. Va. U.S.A. Allegany County

Female White Jan. 28, 1929 20

Female Lee Miller October 21, 1962 2-125

311159

LEASURE-STEIN FUNERAL HOME				STATE OF MARYLAND			
1. FOR STATE REGISTRAR 230 Baltimore Avenue Cumberland, MD 21502				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
REG. NO.				8 5 2 6 9 6 8			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Gilbert Lester Markwood</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 31, 1985</b>		2b. HOUR <b>1:50a</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 8, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS <b>69</b> YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Street Dept.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Allegany Cumberland</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>833 Columbia Ave. 21502</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James W. Markwood</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose E. Raines</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No ---</b>		16b. SOCIAL SECURITY NO. <b>217104005</b>		17. INFORMANT ADDRESS <b>Mary K. Markwood 833 Columbia Ave. Cumberland, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diffuse Pulmonary Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hodgkins Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 day</b> <b>3 wks</b> <b>2 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>10/31 85</b>			
22a. I certify that (1) this hospital attended the deceased from <b>8/10/16</b> 19 <b>85</b> , to <b>10/31</b> 19 <b>85</b> , that (1) (we) last saw the deceased alive on <b>10/31</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (and not) view the body after death.							
22b. SIGNATURE <b>Richard G. Schmitt</b> MD DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/2/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard G. Schmitt, M.D.</b>				22e. ADDRESS <b>912 Seton Drive, Cumberland, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/3/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>	
24. FUNERAL DIRECTOR NAME <b>Leasure-Stein Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>NOV 05 1985</b>			
230 Baltimore Ave. Cumberland, MD 21502							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

Alameda County,

517.04002

298126

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

ITEM NUMBER 11, PER-PH. CALL 1-800-368-6868										STATE OF MARYLAND	
FOR STATE REGISTRAR 10-28-85 D.W.										DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>Nelson Horst Martin</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <b>10-13-85 5:00 PM</b>			2b. DATE PRONOUNCED DEAD <b>10/13/85 6:30 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>03-28-34</b>		6. AGE (IN YEARS) <b>51</b> YRS.		7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD <b>10/13/85</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>LaVale, Md.</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DOA</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-employed</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Agricult.</b>		
13a. STATE <b>PA</b>						13b. COUNTY <b>Bedford</b>		13c. CITY OR TOWN <b>Clearville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Lewis</b> MIDDLE <b>S.</b> LAST <b>Martin</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Fannie</b> MIDDLE <b>Horst</b> LAST <b>Horst</b>			16. SOCIAL SECURITY NO. <b>215/36/6727</b>		
17. INFORMANT ADDRESS <b>Dorothy Martin - same as above</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Brain tumor</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Brain tumor</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo, M.D.</b>				ADDRESS <b>900 seton drive, Cumberland, MD</b>				DATE SIGNED <b>10/13/85</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Oct. 17, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Flintstone Mennon.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Flintstone, Allegany, MD</b>			
24. FUNERAL DIRECTOR NAME <b>John J. Hafer, Jr.</b>				ADDRESS <b>LaVale, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1985</b>			
								25b. REGISTRAR'S SIGNATURE <b>John J. Hafer, Jr.</b>			

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Leasure-Stein Funeral Home

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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1. FOR STATE REGISTRAR  
230 Baltimore Ave  
Cumberland, MD 21502

## CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Harold</u> MIDDLE <u>Frederick</u> LAST <u>Metzger</u> <del>Frederick H. Metzger</del>			2a. DATE OF DEATH MONTH DAY YEAR <u>October 12, 1985</u>		2b. HOUR <u>1:30AM</u>				
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Dec. 11, 1913</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <u>71</u>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Allegany County, MD</u>			
10. CITY OR TOWN OF DEATH <u>Cumberland</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sacred Heart Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Brewer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Brewery Co.</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Allegany</u>		13c. CITY OR TOWN <u>Cumberland</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>320 Baltimore Ave. 21502</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Conrad Metzger</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elizabeth Higgins</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>214054769</u>		17. INFORMANT ADDRESS <u>Beverly Metzger, wife sameas 13a-e.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured thoracic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Abdominal aortic aneurysm</u>									
19a. DATE OF OPERATION <u>11 Oct 85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Abdominal aortic aneurysm</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>122 S. Centre Street, Cumberland, MD 21502</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>11 Oct 85</u> to <u>12 Oct 85</u> , that (I) (we) lost saw the deceased alive on <u>11 Oct 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Frederick Miltenberger</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12 Oct 85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frederick Miltenberger, M.D.</u>				22e. ADDRESS <u>122 S. Centre Street, Cumberland, MD 21502</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>10/14/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Smithsburg Wash. MD</u>			
24. FUNERAL DIRECTOR NAME <u>Leasure-Stein Funeral Home, Inc.</u>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>OCT 15 1985</u>					
230 Baltimore Ave. Cumberland, MD 21502									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1230 Belmont Ave  
Orlando, FL 32803

Frederick W. Meyer  
October 12, 1985  
1:50A

Allegany County

Garrettsville Hospital

214024789

Frederick W. Meyer, M.D.  
123 S. Centre Street, Orlando, FL 32803

297030

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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26971

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DOMENICA MONTGOMERY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 8, 1985</b>		2b. HOUR <b>9:15A.</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 19 1922</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>House</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Westernport</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>222 Walnut St. 21562</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pasquale Delfini</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Theresa Miller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-72-2755</b>		17. INFORMANT ADDRESS <b>Mr. Edwin Montgomery Westernport, Md. 21562</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>August 7.3</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/11/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. FIGUEROA</b>				22e. ADDRESS <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND 21502 MEDICAL BUILDING</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/11/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Westernport Allegany Md. STATE</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Boals Funeral Service Westernport, Md. 21562</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John T. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove said permit to Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSOWERS FUNERAL HOME  
60 W. MAIN STREET  
FROSTBURG, MD 21532  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

2 6 9 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE MARGARET LAST MORGAN			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 16, 1985			2b. HOUR 9:30 AM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 9/21/20		
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR			12b. KIND OF BUSINESS OR INDUSTRY COLLEGE FOOD SERV.					
13a. STATE MARYLAND			13b. CITY OR TOWN FROSTBURG			13c. STREET ADDRESS / ZIP CODE 43 MAPLE STREET 21532		
14. FATHER'S NAME FIRST MIDDLE LAST DAVID GARDNER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL MAE KELLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N.A.			17. INFORMANT RFD FROSTBURG, MD 21532 MR. JOHN GURLEY, WRIGHTS CROSSING,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung cancer & liver + bone metastases DUE TO, OR AS A CONSEQUENCE OF (b) + bone metastases DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Atherosclerosis								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10/14 85 10/16 85		
22a. I certify that (I) (this hospital) attended the deceased from 10/16 19 85, that (I) (we) last saw the deceased alive on 10/16 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE R. Espina, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/16/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RENATO ESPINA, MD						22e. ADDRESS 907 SETON DRIVE, CUMBERLAND, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/19/85			23c. NAME OF CEMETERY OR CREMATORY REST LAWN MEM GDNS LaVALE ALLEGANY MD		
24. FUNERAL DIRECTOR SOWERS FUNERAL HOME			25. ADDRESS 60 W. MAIN ST. FROSTBURG			26. DATE REC'D BY REGISTRAR OCT 23 1985		
27. REGISTRAR'S SIGNATURE James Gordon			28. REGISTRAR'S SIGNATURE James Gordon					

MEDICAL CERTIFICATION





310010

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 7 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RHODA V NEAL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 21, 1985</b>		2b. HOUR MIN. <b>12:52A.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 26, 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>98</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Neal</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ann Jacobs</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>232-52-7369</b>	
17. INFORMANT ADDRESS <b>Mary Neal, Frostburg, Md. 21532</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial Endocarditis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Urinary Tract Infection</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Osteomyelitis of the Condylar Process</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. Schwartz</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/21/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Schwartz</b>		22e. ADDRESS <b>Frostburg Plaza Frostburg, Maryland 21532</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 23, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegany, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Durst Funeral Home, Frostburg, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 29 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodden</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case.

Serial 60-23,1985 Drafting Memorial Book Project, Allegany, Md.

• MM , 2010-11-19 , 10:00 AM

296133

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

26974

1- FOR STATE REGISTRAR  
GEORGE-UPCHURCH F.H.  
202 GREENE STREET  
CUMBERLAND, MD 21502

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CUMBERLAND, MD 21502</b>		LAST <b>PRICE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10 06 85</b>		2b. HOUR <b>6:15 P.M.</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 2, 1917</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>68</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>	
10 CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Investigator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Firm Investigating</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William D. Price</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah - Crosten</b>		13e. STREET ADDRESS / ZIP CODE <b>1315 Frederick St. / 21502</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.II 217106028</b>		17. INFORMANT ADDRESS <b>Gloria Cuellar 1721 Frederick St. Cumberland, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Korsakoff - Wernicke's Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Alcohol related dementia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hepato cellular dysfunction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Mon</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 18</b> 19 <b>85</b> to <b>Oct 6</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>Oct 6</b> 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Paul Livengood M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/9/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL LIVENGOOD, M.D.</b>				22e. ADDRESS <b>BMG 912 SETON DRIVE, CUMBERLAND, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-9-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Meml. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale-Allegany Co.-Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>George-Upchurch Funeral Home, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1985</b>		25b. REGISTRAR'S SIGNATURE	
202 Greene Street-Cumberland, Md. 21502							

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PAUL LIVERGOOD, M.D.

500 012 SETON DRIVE, CUMBERLAND, MD 21502

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SACRED HEART HOSPITAL

ALBANY COUNTY

KEVIN CHARLES PRICE

10 06 82

5:15 P.M.

CUMBERLAND, MD 21502  
302 FRANK STREET

CUMBERLAND, MD 21502

289006

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 7 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) John E. Raley, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 10 02 85			2b. HOUR 10:35 P				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7/7/21		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIONS MANOR NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY CELANESE		
13a STATE MARYLAND			13b COUNTY ALLEGANY		13c CITY OR TOWN FROSTBURG		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE RT. 2, BOX 223 21532	
14 FATHER'S NAME FIRST MIDDLE LAST CLARENCE M. RALEY			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARBARA MCKENZIE							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A. 215-16-4441		17 INFORMANT ADDRESS RFD FROSTBURG, MD 21532 MRS. PATRICIA BEECHIE, VALE SUMMIT.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the lungs</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Diabetes Mellitus</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-27</u> , 19 <u>85</u> , to <u>10-2</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9-27</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>V. A. Ranjithan</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10-3-85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.			22e. ADDRESS LMNH, Seton Drive, Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/5/85		23c. NAME OF CEMETERY OR CREMATORY FINZEL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FINZEL GARRETT MD			
24. FUNERAL DIRECTOR <u>W. M. Sowers</u>			60 W. MAIN ST. SOWERS FUNERAL HOME FROSTBURG			25a. DATE REC'D. BY REGISTRAR OCT 10 1985			25b. REGISTRAR'S SIGNATURE <u>John Davidson Randall</u>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Registered by the hospital or attending physician.

BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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311115

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MICHAEL MARCELLUS RHODES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 28, 1985</b>		2b. HOUR <b>7:45A.M.</b>				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05-08-1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carmen</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>WV</b>			13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Ridgeley</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Martin Rhodes</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bridget Marie Handley</b>			13e. STREET ADDRESS / ZIP CODE <b>55 Carpenter Avenue/26753</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-16-3953</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy J. Rhodes, Ridgeley, WV - wife</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction &amp; Coronary</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>?</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Generalized Arteriosclerosis.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> , 19 <b>85</b> , to <b>10/28</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10/27</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Walter N. Himmler, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/29/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. WALTER HIMMLER</b>				22e. <b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-30-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>			
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, MD 21502</b>				25a. DATE RECD. BY REGISTRAR <b>OCT 31 1985</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove signature papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

2 6 9 7 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Ronald Lee Riley			2a. DATE OF DEATH MONTH DAY YEAR October 5, 1985			2b. HOUR 5:13a.m.				
3. SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4/20/34		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp. & Med. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER		12b. KIND OF BUSINESS OR INDUSTRY SPORTING GOODS		
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 239 E. MAIN ST. 21532	
14. FATHER'S NAME FIRST MIDDLE LAST VERNON RILEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN ATKINSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A.		17. INFORMANT ADDRESS FROSTBURG, MD 21532 MRS. NORMA RILEY, 239 E. MAIN ST.,					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

from negative sepsis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

Pseudomonas pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

Massive obesity &amp; renal failure

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Morbid obesity, respiratory failure.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. N. Ranjithan				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Ranjithan				22e. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland 21502			

23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 10/7/85		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM PK		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD	
24. FUNERAL DIRECTOR M. Sowers 60 W. MAIN ST. SOWERS FUNERAL HOME FROSTBURG				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 15 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 7 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LESTER CLIFTON RITCHIE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 12, 1985</b>		2b. HOUR <b>3:35</b> AM	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 12, 1919</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10 CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital &amp; Medical Center</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		
12b KIND OF BUSINESS OR INDUSTRY <b>Glass Co.</b>		13a STATE <b>Maryland</b>				
13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Spring Gap</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET ADDRESS / ZIP CODE <b>none</b>		21560				
14 FATHER'S NAME FIRST MIDDLE LAST <b>Perry A. Ritchie</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Wince</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>213-12-9397</b>		17 INFORMANT ADDRESS <b>Mrs. Evelyn Ritchie, Spring Gap, Md. Wife</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ASCVD</u> <u>6 Ventricular aneurysm</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4 Oct</u> , 19 <u>85</u> , to <u>12 Oct</u> , 19 <u>85</u> , that (I) (we) last saw the deceased <u>alive</u> <u>11 Oct 85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Dr. A. Bollino, Jr.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>13 Oct 85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. A. Bollino, Jr.</b>		22e. ADDRESS <b>955 Frederick St., Cumberland MD 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-14-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Near Oldtown, Md.</b>		24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md. 21502</b> ADDRESS				
25a. DATE REC'D. BY REGISTRAR <b>Oct 18 1985</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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COCK CO. ON FIRE



10-11-1941

10-11-1941



304187

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GLORIA JEAN ROTRUCK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 9, 1985</b>		2b. HOUR <b>11:05</b> a.m.				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 12 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>WV</b>				13b. CITY OR TOWN <b>Grant</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>Box 99 A Antioch Route New Creek, WV 26743</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Kenny E. Davis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Ketterman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>234-38-9079</b>		17. INFORMANT <b>Walter T. Rotruck</b>		ADDRESS <b>Box 99 A Antioch Route New Creek, WV 26743</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>NS</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY/TOWN COUNTY STATE <b>9102 85 1019 85</b>					
22a. I certify that (I) this hospital attended the deceased from <b>9/12/85</b> to <b>10/9/85</b> , that (I) (we) last saw the deceased alive on <b>10/9/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not) view the body after death.									
22b. SIGNATURE <b>Dr. W. Guy Fiscus</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/18/85</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. W. Guy Fiscus</b>				22e. ADDRESS <b>500 Memorial Ave., Memorial Med. Bldg. Cumberland, MD 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 12 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Thrush Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Antioch Mineral WV</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>A. Craig Rotruck 85 S Main St Keyser, WV 26726</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 23 1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>			

30117



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

295104

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Florence Clara Savarese</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10/14/85</i>			2b. HOUR <i>1:25 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 30 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Allegany County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Cumberland</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cumberland Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Allegany</i>		13c. CITY OR TOWN <i>Cumberland</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John W. Boone</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lucy --- Conard</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>113-07-5991</i>		17. INFORMANT ADDRESS <i>Cumberland, Md.</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonitis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebro-Vascular Accident</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Rheumatic Heart Disease with Mitral Stenosis</i>			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 19</i> 19 <i>85</i> , to <i>Oct. 2</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>Oct. 8</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>S. M. Shrestha</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. M. SHRESTHA</i>		22e. ADDRESS <i>The Memorial Hospital Cumberland, Md. 21502</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10-16-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Burial P.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cumberland Allegany Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Cumberland, Md. 21502 Leasure-Stein F. Home 230 Baltimore Av.</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 18 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Gula Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 8 1

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM HENRY SEE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 20, 1985</b>		2b. HOUR <b>4:12 a.m.</b>								
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08-08-1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.							
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Brewing Co.</b>					
13a. STATE <b>MD</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE <b>210 Cole Street/21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Casson See</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sally Emily See</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>232-26-0950</b>		17. INFORMANT ADDRESS <b>Mrs. Waveley See, Cumberland, MD 21502-wife</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/10/85</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>10/20/85</b>							
22. I certify that (I) (this hospital) attended the deceased from <b>10/10/85</b> to <b>10/20/85</b> that (I) (we) last saw the deceased alive on <b>10/20/85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.													
23a. SIGNATURE <b>Dr. Guy Fiscus</b>						DEGREE		23b. DATE SIGNED <b>10/21</b>					
23c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Guy Fiscus</b>						23d. ADDRESS <b>Memorial Hospital Medical Building Cumberland, MD 21502</b>							
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23f. DATE <b>10-23-1985</b>		23g. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23h. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>					
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, MD 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John F. ...</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, great care must be taken to avoid an error.

BP





296007

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by a physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.			
1. STATE REGISTRAR				202 GREENE STREET CUMBERLAND, MD. 21502				8 5 2 6 9 8 2			
DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR			
ETHEL GENEVIEVE SKELLEY								OCTOBER 15, 1985			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7b. HOUR	
Female		White		May 7, 1912		73 YRS				04:28A M	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		SACRED HEART HOSPITAL				Celanese & Waitress		-Restaurant			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Allegany		Cresaptown				Brant Road / 21502			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James - Stottlemeyer				Molly - Clingerman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		218-24-7861		James M. Skelley-Address same as #13 above.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Renal failure</u>										3 wks	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>										10 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
<u>Emphysema, Respiratory failure</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost											
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>George V. Mazzocco</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>10-16-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
DR. EUGENE V. MAZZOCCO, M.D.				BMG, 912 SETON DR., CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		10-17-85		St. Ambrose Cemetery		Cresaptown-Allegany Co.-Md.					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland				OCT 21 1985							

BP

200000

GEORGE ORCHARD  
203 GERRIE STREET  
STURGEON, N.D. 58152

STURGEON, N.D. 58152

ETHEL GENEVIEVE SKELLEY OCTOBER 12, 1988 04:00A

ALLIANCE COUNTY

SACRED HEART HOSPITAL

316-24-7001

DR. EUGENE V. HATZKOCC, M.D. INC, 912 SETON DR., CUMBERLAND, MD. 21502

289004

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 8 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edna Frances Smith</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/6/85</b>			2b. HOUR <b>1:35 A</b>				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 - 22 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Village Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machine</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>		
13a. STATE <b>MD.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>LaVale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Henry Wolf</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louisa Denton Startzman</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-54-1475</b>	
17. INFORMANT ADDRESS <b>19 Park Ave.</b>			18. CITY OR TOWN <b>LaVale, Md.</b>			19. STATE <b>21502</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Long interval</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**old age**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/12</b> , 19 <b>85</b> , to <b>10/6</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>SL Sandhir M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/7/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. S. L. Sandhir M.D.</b>				22e. ADDRESS <b>48 Tarn Terr Frostburg, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-9-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale Allegany Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Silcox-Merriitt 404 Decatur St. Cumb. Md. 21502</b>				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>OCT 10 1985 Julia Davidson</b>			

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1 - FOR  
STATE  
REGISTRAR

10/23/95 rja

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lillie Belle Smith</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>October 6, 1985</b>		2b. HOUR <b>12:30a.m.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 3, 1896</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>89</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hosp. &amp; Medical Center</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Denton O. Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Virginia E. Norris Pensinger</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>232-26-3702</b>		17. INFORMANT ADDRESS <b>Virginia Bosley 835 Shriver Avenue Cumberland, MD 21502</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive Pulmonary Disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GI bleeding, old age.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>GI bleeding, old age.</b>					
19a. DATE OF OPERATION <b>10/6/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>old age</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. N. Ranjithan</b>				22c. DATE SIGNED <b>10/6/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. N. Ranjithan</b>				22e. ADDRESS <b>Memorial Hospital Medical Building Cumberland, MD 21502</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/8/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Piney Plains Cemetery Little Orleans Alleg. MD</b>	
24. FUNERAL DIRECTOR NAME <b>Leasure-Stein Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 9 1985</b>		25b. REGISTRAR'S SIGNATURE <b>G. Davidson</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Alleg. MD</b>		23e. ADDRESS <b>230 Baltimore Ave. Cumberland, MD 21502</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The I

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed in accordance with the instructions given by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 shall be filed within 24 hours after death with the State Health Department. Page 2 should be retained by the funeral director and be available for inspection by the State Health Department, the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked **positive**, it shows any injury, or other traumatic event, the r





297038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 6 9 8 5

FOR  
1 - STATE  
REGISTRAR

REG. NO. \_\_\_\_\_

1. DECEASED NAME (TYPE OR PRINT) <b>TYRUS HARDING SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 14, 1985</b>			2b. HOUR <b>1:15 a. m.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT 26 1920</b>		6. AGE (IN YEARS- LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital &amp; Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED CONSTRUCTION</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>703 BAKER STREET 21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY WILLIAM SMITH</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA E. ORNDORFF</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW1 214-12-3414</b>		17. INFORMANT ADDRESS <b>BETTY SMITH 703 Baker Street Cumberland Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diffuse Metastatic Ca.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Prostate</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i> MD DEGREE						22c. DATE SIGNED <b>Oct 15, 1985</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Q. Zaman</b>						22e. ADDRESS <b>Memorial Hospital Medical Building Cumberland, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>OCT 17 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Gap Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Silcox-Merritt Funeral Home - Cumberland Md.</b>									

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 5 2 6 7 8 0			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2. DATE OF DEATH			
John Edward TRIMBLE				10 26 85 7 PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
MALE		NEGRO		4 7 93		92 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				ALLEGANY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Frostburg		FROSTBURG VILLAGE Nursing Home		unknown		---	
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Allegany		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		North Mechanic St. 21502	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Charles F. Trimble		Rebecca Holly		Yes WWT			
16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
214-05-7247		John L. Holmes		Pittsburgh, PA			
19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Feb 22 19 79 to Oct 26 19 85, that (I) (we) last saw the deceased alive on Oct 26 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Dr. Shin Kim		MD					
22d. PHYSICIAN'S ADDRESS (TYPE OR PRINT)		22e. ADDRESS					
Dr. Shin Kim		90 W. Main St. Westernport, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		10/30/85		Rocky Gap Veterans		Flintstone Alleg. MD	
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leasure-Stein Funeral Home, Inc.		OCT 30 1985					
230 Baltimore Ave. Cumberland, MD 21502							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>NORA C. TROXELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 9, 1985</b>			2b. HOUR <b>9:25 P.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 26 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS <b>925</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NURSING + CONVALESCENT CENTER</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Librarian</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Library</b>	
13a. STATE <b>MD.</b>	13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>716 Gephart Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elnora Foster</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-32-8263</b>		17. INFORMANT <b>Mr. Ted Troxell</b> ADDRESS <b>12916 North Cresap Street Bowling Green, Cumb., Md.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**fr - ve sepsis.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Pauline Smith d.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3/2 19 85 to 1-19 85</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/7 85</b> to <b>1-19 85</b> , that (I) (we) last saw the deceased alive on <b>10/7 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE <b>P. HAZMOS</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/11/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>302 Schley St Cumberland</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10-12-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Md.</b>
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24. FUNERAL DIRECTOR NAME ADDRESS <b>Silcox-Merritt 404 Decatur St., Cumb., Md. 21502</b>	25a. DATE REC'D BY REGISTRAR <b>OCT 15 1985</b>
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. DECEASED NAME (TYPE OR PRINT) <b>Franklin Thomas Twigg, Sr.</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 10-11 19 85	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 11 1915</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>70</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Water Dept</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Westminster</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward R. Twigg</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma E. Buser</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>220-03-7825</b>	
17. INFORMANT <b>Son</b>		ADDRESS <b>Franklin Thomas Twigg, Ridgeley, W. Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dr. Giovanni Mastrangelo</i>		TITLE (SPECIFY) <b>deputy</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Giovanni Mastrangelo MD</b>		DATE <b>10-12-1985</b>	
ADDRESS <b>Seton Drive, Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10-15-1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oldtown, Allegany, Md.</b>
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 18 1985</b>	
		25b. REGISTRAR'S SIGNATURE <i>John T. ...</i>	

SECTION 11066

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>OSCAR</b>		FIRST <b>Waltman</b>		LAST <b>Waltman</b>		2a. DATE OF DEATH MONTH <b>10</b> DAY <b>31</b> YEAR <b>85</b>		2b. HOUR <b>6:30</b> AM	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH <b>12</b> DAY <b>7</b> YEAR <b>13</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.			
10 CITY OR TOWN OF DEATH <b>FROSTBURG</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FROSTBURG NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>textile</b>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Frostburg Nursing Home</b>	
14 FATHER'S NAME FIRST <b>William</b> MIDDLE <b>L.</b> LAST <b>Waltman</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Susannah</b> MIDDLE <b>Luman</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217 10 5534</b>		17 INFORMANT ADDRESS <b>Ted Femi, Gramlich Road, La Vale, MD 21502</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>OPD: ante exuberant</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHE. Schizophrenia, paranoid</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Type</b>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>90 Main St., Westernport, MD</b>		CITY OR TOWN <b>Westernport</b>		COUNTY <b>Allegany</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 29, 1985</b> to <b>March 29, 1985</b> , that (I) (we) lost saw the deceased alive on <b>March 29, 1985</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Kim Shin Eung MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>NOV 5 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kim Shin Eung MD</b>				22e. ADDRESS <b>90 Main St., Westernport, MD</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/2/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>COOKS HILLS CEM.</b>		23d. LOCATION CITY OR TOWN <b>RD, Hyndman, Bedford, PA</b>			
24 FUNERAL DIRECTOR NAME <b>Harvey H. Zeigler, Hyndman, PA</b>		ADDRESS <b>Harvey H. Zeigler, Hyndman, PA</b>		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>NOV 5 1985</b> <b>John Davidson</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NEWMAN FUNERAL HOME				STATE OF MARYLAND			
1- FOR STATE REGISTRAR Po Box 267 Grantsville, md				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
				CERTIFICATE OF DEATH			
				REG. NO. 3 5 2 6 9 9 0			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leonard Edward Wampler</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 7, 1985</b>		2b. HOUR <b>23:15p</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 17, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>80</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, MD</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Carpentry</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>GARRETT</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE (Rural Garrett Co) <b>Star Rt., Box 31 21532</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Jonas E. Wampler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Ann Lancaster</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>218077299</b>		17. INFORMANT <b>Raymond Wampler, Swanton, MD</b>		17a. ADDRESS <b>Route 2, Box 229</b>		17b. CITY OR TOWN <b>Swanton, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Carcinoma of Stomach with Metastases to Liver</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 23, 19 85</b> to <b>Oct. 7, 19 85</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <b>W. Hijab, M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/8/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wally Hijab, M.D.</b>				22e. ADDRESS <b>909-A Seton Drive, Cumberland, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-10-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grantsville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Grantsville, Garrett, MD</b>	
24. FUNERAL DIRECTOR NAME <b>A. L. ...</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT. 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson ...</b>	

2001

October 7, 1982

James Earl Ray

Albany County

Shirley Ann Ray

21807209

900-A Second Drive, Cantonland, MO 63025

Early High, M.A.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

289116

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WILBUR WEAVER		2a. DATE OF DEATH MONTH DAY YEAR 10 04 85	
3. SEX MALE		2b. HOUR 2:40P M	
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08 03 13	
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Ed. of Education	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE WV 13b COUNTY Mineral 13c CITY OR TOWN Ridgeley		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 584 / 26753 99999		14. FATHER'S NAME FIRST MIDDLE LAST Claude G. Weaver	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Dawson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 214-07-2742		17. INFORMANT ADDRESS Margaret L. Weaver, Ridgeley, WV - wife	
18. CAUSE OF DEATH Enter only one cause per line for (1) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)			
18. CAUSE OF DEATH Enter only one cause per line for (1) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 22c. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE) CUMBERLAND ALLEGANY MD	
23. I certify that (1) (this hospital) received the deceased from <u>last several years</u> to <u>Oct. 4 85</u> , that (1) (we) last saw the deceased alive on <u>Oct. 2, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (do) (not) view the body after death.			
24. SIGNATURE <u>Terry Williams</u>		25. DATE SIGNED 10-4-85	
26. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams		27. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502	
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		28b. DATE 10-07-1985	
28c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		28d. LOCATION (CITY OR TOWN, COUNTY, STATE) Cumberland Allegany MD	
29. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		30. DATE REC'D. BY REGISTRAR OCT 9 1985	
31. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

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CHIEF

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100% COTTON FIBRE

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ROTRUCK FUNERAL HOME

85 S MAIN STREET

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

STATE OF MARYLAND

1- FOR REGISTRAR KEYSER, ~~MAXXX~~

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CARL BROGDON WELCH, Jr.			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 10, 1985			2b HOUR 2:10 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1926		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10 CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trainmaster Chessie		12b KIND OF BUSINESS OR INDUSTRY Sistem	
13a STATE W. Va.				13b COUNTY Mineral		13c CITY OR TOWN Keyser		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Carl B. Welch, Sr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude - Reed					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17 INFORMANT ADDRESS Jo Ann Welch 124 S. Water St. Keyser, W. Va.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Colon</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 Months</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>8/5/85</i> to <i>10/10/85</i> that (I) (we) last saw the deceased alive on <i>10/9/85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Richard Snider</i>				22c DATE SIGNED <i>10/10/85</i>				22d PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SNIDER, MD	
22e ADDRESS P.O. BOX 2455, CUMBERLAND, MD 21521									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 13 Oct 85		23c NAME OF CEMETERY OR CREMATORY Queens Point		23d LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W. Va.			
24 FUNERAL DIRECTOR Allen Rotruck Keyser, W. Va.				25a DATE REC'D. BY REGISTRAR OCT 17 1985		25b REGISTRAR'S SIGNATURE <i>G. Davidson</i>			

MEDICAL CERTIFICATION



296024

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP\_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		22b. HOUR					
Louis		Stanley		Wentling				20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		22b. HOUR					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		24. HOUR	
Male		White		7. DATE OF BIRTH		8. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		24. HOUR	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. BOX NO.		13g. ZIP CODE	
Oldtown		Bear Creek Rd.,		Farmer		Farm		Md.		Allegany		Oldtown		YES		RFD# 1, Box 327		21555			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. DATE OF OPERATION		21. CONDITION FOR WHICH OPERATION WAS PERFORMED?		22. AUTOPSY?		23. DATE	
Bernard		Emma		No.		212-12-8585		Mrs. Agnes Slider		Intracerebral hemorrhage								YES		10-13-85	
24. FATHER'S NAME		25. MOTHER'S MAIDEN NAME		26a. WAS DECEASED EVER IN U.S. ARMED FORCES?		26b. SOCIAL SECURITY NO.		27. INFORMANT		28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		30. DATE OF OPERATION		31. CONDITION FOR WHICH OPERATION WAS PERFORMED?		32. AUTOPSY?		33. DATE	
Bernard		Emma		No.		212-12-8585		Mrs. Agnes Slider		Gunshot wound to head, self-inflicted								YES		10-13-85	
34. FATHER'S NAME		35. MOTHER'S MAIDEN NAME		36a. WAS DECEASED EVER IN U.S. ARMED FORCES?		36b. SOCIAL SECURITY NO.		37. INFORMANT		38. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		39. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		40. DATE OF OPERATION		41. CONDITION FOR WHICH OPERATION WAS PERFORMED?		42. AUTOPSY?		43. DATE	
Bernard		Emma		No.		212-12-8585		Mrs. Agnes Slider		Gunshot wound to head, self-inflicted								YES		10-13-85	
44. FATHER'S NAME		45. MOTHER'S MAIDEN NAME		46a. WAS DECEASED EVER IN U.S. ARMED FORCES?		46b. SOCIAL SECURITY NO.		47. INFORMANT		48. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		49. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		50. DATE OF OPERATION		51. CONDITION FOR WHICH OPERATION WAS PERFORMED?		52. AUTOPSY?		53. DATE	
Bernard		Emma		No.		212-12-8585		Mrs. Agnes Slider		Gunshot wound to head, self-inflicted								YES		10-13-85	
54. FATHER'S NAME		55. MOTHER'S MAIDEN NAME		56a. WAS DECEASED EVER IN U.S. ARMED FORCES?		56b. SOCIAL SECURITY NO.		57. INFORMANT		58. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		59. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		60. DATE OF OPERATION		61. CONDITION FOR WHICH OPERATION WAS PERFORMED?		62. AUTOPSY?		63. DATE	
Bernard		Emma		No.		212-12-8585		Mrs. Agnes Slider		Gunshot wound to head, self-inflicted								YES		10-13-85	
64. FATHER'S NAME		65. MOTHER'S MAIDEN NAME		66a. WAS DECEASED EVER IN U.S. ARMED FORCES?		66b. SOCIAL SECURITY NO.		67. INFORMANT		68. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		69. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		70. DATE OF OPERATION		71. CONDITION FOR WHICH OPERATION WAS PERFORMED?		72. AUTOPSY?		73. DATE	
Bernard		Emma		No.		212-12-8585		Mrs. Agnes Slider		Gunshot wound to head, self-inflicted								YES		10-13-85	
74. FATHER'S NAME		75. MOTHER'S MAIDEN NAME		76a. WAS DECEASED EVER IN U.S. ARMED FORCES?		76b. SOCIAL SECURITY NO.		77. INFORMANT		78. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		79. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		80. DATE OF OPERATION		81. CONDITION FOR WHICH OPERATION WAS PERFORMED?		82. AUTOPSY?		83. DATE	
Bernard		Emma		No.		212-12-8585		Mrs. Agnes Slider		Gunshot wound to head, self-inflicted								YES		10-13-85	
84. FATHER'S NAME		85. MOTHER'S MAIDEN NAME		86a. WAS DECEASED EVER IN U.S. ARMED FORCES?		86b. SOCIAL SECURITY NO.		87. INFORMANT		88. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		89. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		90. DATE OF OPERATION		91. CONDITION FOR WHICH OPERATION WAS PERFORMED?		92. AUTOPSY?		93. DATE	
Bernard		Emma		No.		212-12-8585		Mrs. Agnes Slider		Gunshot wound to head, self-inflicted								YES		10-13-85	
94. FATHER'S NAME		95. MOTHER'S MAIDEN NAME		96a. WAS DECEASED EVER IN U.S. ARMED FORCES?		96b. SOCIAL SECURITY NO.		97. INFORMANT		98. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		99. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		100. DATE OF OPERATION		101. CONDITION FOR WHICH OPERATION WAS PERFORMED?		102. AUTOPSY?		103. DATE	
Bernard		Emma		No.		212-12-8585															

SDR031

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]  
[Illegible text block]





BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of fact and cause.

289065

1- FOR 1302 National Hwy STATE REGISTRAR Lavale, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 5 2 6 9 9 4			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Fred Addison Wilson</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>October 8, 1985</b>				2b. HOUR <b>12:30am</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 6, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>130 Downing St/21502</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sidinous T. Wilson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Van Slyke</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>069037290</b>		17. INFORMANT ADDRESS <b>Doris H. Wilson - same as above</b>							
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Profound Metabolic Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Disseminated Metastatic Carcinoma from the Prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Nausea + Vomiting due to Paralytic Ileus</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Transitional Cell Carcinoma of the Urinary Bladder.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE <b>9/22 85 10/8 85</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>10/8 85</b> to <b>10/8 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) examine the body after death.											
22b. SIGNATURE <b>V. R. FELIPA</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>10/8/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. R. FELIPA</b>				22e. ADDRESS <b>925 Bishop Walsh Rd</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 10, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Mem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale, Allegany, MD</b>			
24. FUNERAL DIRECTOR NAME <b>John J. Hafer, Jr.</b>				ADDRESS <b>LaVale, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1985</b>			
				25b. REGISTRAR'S SIGNATURE <b>Julia F. Anderson</b>							

2898

312023

FOR STATE REGISTRAR  
Sowers Funeral Home  
250 W. Main Street  
Frostburg, MD 21532

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 26995

1. DECEASED NAME (TYPE OR PRINT) Kathleen Fern Wilson			2a. DATE OF DEATH MONTH DAY YEAR October 26, 1985			2b. HOUR 11:30p <small>AM</small>			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7/28/22		6. AGE (IN YEARS (LAST BIRTHDAY)) 63 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LORD, MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN SHAFT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT 1, BOX 111 21532	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL MCKENZIE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA CROFT				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N.A.	
16a. SOCIAL SECURITY NO. 217184879				17. INFORMANT FROSTBURG, MD 21532 MR. PAUL T. WILSON, RT 1, BOX 111,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Ca of breast &amp; Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			9c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		9d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10-12, 1985</u> , to <u>10-26, 1985</u> , that (I) (we) lost saw the deceased alive on <u>10-26, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John Mehanna</u>			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-27-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Mehanna, M.D.			22e. ADDRESS 909-B Seton Drive, Cumberland, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SEEKEY) BURIAL			23b. DATE 10/28/85		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEM		23d. LOCATION CITY OR TOWN COUNTY STATE GARRETT MD		
24. FUNERAL DIRECTOR <u>Walter M. Sowers</u>			60. DREW W. MAIN ST.			25a. NOV 04 1985			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top portion, pages 1 and 2, and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked as item 18, above, injury, or other traumatic event, the medical examiner must be notified at once.

BP

315033

Home of the  
60 N. Main Street  
Providence, RI 02903

October 26, 1985 11:30p

William John

7/28/85

WHITE

Allegany County

ROAD, WYOMING U.S.A.

Samuel Henry Hospital

NEW BRUNSWICK

OWN HOME  
EROTICISM  
2000

AT 11:30 AM

STREET

GROUP

WYOMING

WYOMING

WYOMING

PROVIDENCE, RI 02903

MR. JOHN T. WILSON, JR. 11:30 AM

21706072

M.A.

NO



902-5 South Main, Providence, RI 02903

John Wilson, M.D.

WYOMING

WYOMING

WYOMING

60 N. Main St.

PROVIDENCE

WYOMING

305129

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 6 9 9 6  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VESTA Rebecca ZEMBOWER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 23, 1985</b>		2b HOUR <b>6:45A.</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 21 98</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>87</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>	
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a STATE <b>MD.</b>		13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Cumberland</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frank</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nora Damer</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-34-2604</b>	
17 INFORMANT ADDRESS <b>George R. Zembower RFD# 3 Bedford Rd. Cumberland, Md. 21502</b>							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Atherosclerotic Heart disease and**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Chronic Obstructive Lung Disease**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Congestive Heart Failure**

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>10-7</b> 19 <b>85</b> to <b>10-23</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10-23</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Dr. Barrera</b>				DEGREE <b>MD</b>		22c DATE SIGNED <b>10-24-85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. BARRERA</b>				22e ADDRESS <b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>10-26-85</b>		23c NAME OF CEMETERY OR CREMATORY <b>P O S of A Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Centerville Bedford Penna</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Silcox-Merritt 404 Decatur St. Cumb.Md. 21502</b>				25a DATE REC'D. BY REGISTRAR <b>OCT 28 1985</b>		25b REGISTRAR'S SIGNATURE <b>Julia Davidson</b>	

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there was any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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